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Essential universal health coverage needs local capacity development



Disease Control Priorities, 3rd edition (DCP3), published in 2017, reanimated academic debate about the value of cost-effectiveness and global knowledge in priority setting for national health policy.¹ In 1993, the first DCP project was published by Jamison and his team² with the support of the World Bank, which was part of a larger project by the World Bank to define health as an investment rather than an expenditure at the international and national levels.³ DCP1 and DCP2, which was published in 2006, both substantially influenced the ways in which the World Bank, WHO, and other global health donors prioritised investment in health interventions in low-income countries (LICs) and lower-middle-income countries (lower-MICs), but they had insufficient uptake by the governments in these countries.⁴ This lack of uptake was partly due, as critics of DCP1 and DCP2 argued, to an overemphasis on the economic evaluation of health interventions over other important factors, including health equity.⁵ Furthermore, insufficient attention was given to the technical capacity required to interpret DCP data and translate it into local health policy.⁶

In response to these critiques, and to update the DCP in alignment with the Sustainable Development Goals, DCP3 was produced with the aim that it would be most useful for ministers of finance in LICs and lower-MICs. Although DCP3 does expand beyond cost-effectiveness to include other objectives such as financial protection, palliative care, and contraception needs,¹ the report prompted further reflection on the role of economic evaluation in health policy making. As the field of health economics has expanded in the past few decades, rapid advances in the development of health economic tools have paradoxically made such tools less useful for decision makers.⁷ Therefore, future versions of the DCP should emphasise health-care needs at the national and local levels, and highlight the importance of country-level technical capacity to understand these needs.⁶ This strengthened technical capacity to interpret and contextualise DCP evidence at the country level should also be paired with reporting and use of direct mortality data rather than modelled data.⁸

In this context, David Watkins and colleagues⁹ have produced a modelling study and an online costing tool—the Disease Control Priorities Cost Model (DCP-CM)—as starting points to help countries prioritise their health packages and achieve what the authors of DCP3 term essential universal health coverage (EUHC). The team has produced cost estimates for the 218 health interventions that comprise the 21 packages of EUHC, and for the 112 interventions within these that comprise a highest priority package in DCP3. The cost estimates are for two stylised countries standing in for LICs and lower-MICs, using the World Bank criteria to define these income groups.

Their study and the online costing tool are invaluable for health financing advocacy—both make clear the need for increased domestic and global financial resources, via modelling the cost of implementing even minimum versions of UHC for countries in the midst of epidemiological transition. Furthermore, DCP-CM undoubtedly provides an important starting point for ministers of finance and health to build budgets for robust national health systems. However, as tools for prioritising interventions in national health policy, this study and the DCP-CM should be accompanied by extensive country-level expertise on actual costs of health interventions and local data on disease burden, alongside other, non-economic forms of evaluation. They provide a reminder of the importance of investing in local capacity development beyond short-term engagement or knowledge produced in a global context. As many researchers have reiterated,^{4–8} building health policy for UHC in LICs and lower-MICs should attend not only to economic evaluation, but also to local values and contexts, the issue of health equity, and investment in local capacity development.

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- 1 Jamison DT, Alwan A, Mock CN, et al. Universal health coverage and intersectoral action for health: key messages from *Disease Control Priorities*, 3rd edition. *Lancet* 2018; **391**: 1108–20.
- 2 Jamison DT, Mosley WH, Measham AR, Bobadilla JL. *Disease Control Priorities in Developing Countries*. New York, NY: Oxford University Press, 1993.
- 3 World Bank. *World development report 1993: investing in health*. New York, NY: Oxford University Press, 1993.
- 4 Davis A, Walker DG. On the path to UHC—global evidence must go local to be useful. *Int J Health Policy Manag* 2018; **8**: 181–83.
- 5 Rumbold B, Baker R, Ferraz O, et al. Universal health coverage, priority setting, and the human right to health. *Lancet* 2017; **390**: 712–14.
- 6 Norheim OF. Priority setting on the path to UHC: time for stronger institutions and stronger health systems: response to recent commentaries. *Int J Health Policy Manag* 2019; **8**: 511–13.
- 7 Brousselle A, Lessard C. Economic evaluation to inform health care decision-making: promise, pitfalls and a proposal for an alternative path. *Soc Sci Med* 2011; **72**: 832–39.
- 8 Jha P. The future of disease control priorities. *Int J Health Policy Manag* 2019; **8**: 177–80.
- 9 Watkins DA, Qi J, Kawakatsu Y, Pickersgill SJ, Horton SE, Jamison DT. Resource requirements for essential universal health coverage: a modelling study based on findings from *Disease Control Priorities*, 3rd edition. *Lancet Glob Health* 2020; **8**: 829–39.